



The Centers for Medicare and Medicaid Services:
SUPPORT Act Section 1003 Grant



SUD Technical Assistance Webinar Series

VIRGINIA MEDICAID: 3— SUICIDE ASSESSMENT & SCREENING

PAUL BRASLER, LCSW

DECEMBER 2, 2020

Department of Medical Assistance Services



Welcome and Meeting Information

- WebEx participants are muted
 - Please use Q&A feature for questions
 - Please use chat feature for technical issues
- Focus of today's presentation is practice-based – please Contact SUD@dmass.virginia.gov with technical or billing questions
- SUPPORT 101 Webinar Series slide decks are available on the DMAS ARTS website – www.dmass.virginia.gov/#/ARTS
- We are unable to offer CEUs for this webinar series



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- **Last revision: November 30, 2020**

DISCLAIMER

The Virginia Department of Medical Assistance Services (DMAS) SUPPORT Act Grant projects are supported by the Centers for Medicare and Medicaid Services (CMS) of the U.S. Department of Health and Human Services (HHS) as part of a financial assistance award totaling \$4,836,765 with 100 percent funded by CMS/HHS. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by CMS/HHS, or the U.S. Government.

Pre-Webinar Survey

In conjunction with the VCU Wright Center and the VCU Institute for Drug and Alcohol Studies, we are conducting a survey for research purposes in order to gain a better understanding of provider impressions and experiences of individuals with substance use disorders (SUDs), medication assisted treatment, and Medicaid. The information obtained will be used to assist in identifying potential barriers to treating these individuals.

If you haven't already, before the start of today's webinar please use the link in the chat to access a brief (less than 5 minutes) electronic survey.

- Your name and contact information will not be linked to your survey responses.
- Your decision to complete the survey is completely voluntary.
- When exiting this webinar, you will be directed to complete the survey again as a post-training assessment. Again, it will be your decision to complete the follow-up survey or not.
- You are able to complete one pre and post survey per each webinar topic you attend.
- Your completion of the pre-webinar survey will enter you into a drawing to win a \$50 Amazon gift card as well as participation in the post-webinar survey will enter you into another \$50 Amazon gift card drawing!

If you have any questions about the current study, please feel free to contact, Dr. Lori Keyser-Marcus at Lori.keysermarcus@vcuhealth.org or (804) 828-4164. Thank you for helping us with this effort!



Naloxone Resources

- Get trained now on naloxone distribution
 - REVIVE! Online training provided by DBHDS every Wednesday
 - <http://dbhds.virginia.gov/behavioral-health/substance-abuse-services/revive/lay-rescuer-training>
 - <https://getnaloxonenow.org/>
 - Register and enter your zip code to access free online training
- Medicaid provides naloxone to members at no cost and without prior authorization!
- Call your pharmacy before you go to pick it up!
- Getting naloxone via mail
 - Contact the Chris Atwood Foundation
 - <https://thecaf.acemlnb.com/lt.php?s=e522cf8b34e867e626ba19d229bbb1b0&i=96A94A1A422>
 - Available only to Virginia residents, intramuscular administration



Upcoming Technical Assistance Opportunities

Webinars for the week of November 30th – December 4th

Wednesday, December 2, 2020

1:00 PM – 2:00 PM: **Suicide Assessment & Screening** - Paul Brasler

<https://covaconf.webex.com/covaconf/onstage/g.php?MTID=e67c2cd6f4fb6b2f5c9271ca42939c6ca>

Webinars for the week of December 7th – December 11th

Tuesday, December 8, 2020

10:00 AM – 11:00 AM: **Suicide Assessment & Screening** - Paul Brasler

<https://covaconf.webex.com/covaconf/onstage/g.php?MTID=ef914dd4962a30dd762a1f8cf142bbd49>

Wednesday, December 9, 2020

1:00 PM – 2:00 PM: **Virginia Medicaid ARTS Care Coordination** - Paul Brasler

<https://covaconf.webex.com/covaconf/onstage/g.php?MTID=eb71b77c587e9474515a59f85a2751a76>

Webinars for the week of December 14th – December 18th

Monday, December 14, 2020

1:00 PM – 2:00 PM: **Opioids & Stimulants Overview** - Paul Brasler

<https://covaconf.webex.com/covaconf/onstage/g.php?MTID=ea31ba2695973ff5962b4c04789174721>

Tuesday, December 15, 2020

10:00 AM – 11:00 AM: **Trauma-Informed Care** - Paul Brasler

<https://covaconf.webex.com/covaconf/onstage/g.php?MTID=e2d7cbec4b17bc044a3c3156669ae4875>

Webinars for the week of December 21st – December 25th

Tuesday, December 22, 2020

10:00 AM – 11:00 AM: **Opioids & Stimulants Overview** - Paul Brasler

<https://covaconf.webex.com/covaconf/onstage/g.php?MTID=ee4880cdd266b8f57b1b4ad5c2d2e3a68>



Website Update



DMAS Home Page:

<https://www.dmas.virginia.gov/#/index>

ARTS Home Page:

<https://www.dmas.virginia.gov/#/arts>



SUPPORT Act Grant Website -

<https://www.dmas.virginia.gov/#/artssupport>

SUPPORT Act Grant Overview

The Virginia Department of Medical Assistance Services (DMAS) was awarded the Centers for Medicare & Medicaid Services SUPPORT Act Section 1003 Grant in September 2019. The purpose of this grant is to decrease substance use disorder (SUD) provider workforce barriers and increase the treatment capacity of providers participating under the state Medicaid program to provide SUD treatment or recovery services.

Grant Goals

- Learn from Addiction and Recovery Treatment Services (ARTS) program
- Decrease barriers to enter workforce
- Focus on specific subpopulations: justice-involved members and pregnant and parenting members
- Maintain our core values: person-centered, strengths-based, recovery-oriented

Grant Components

- Needs assessment
- Strengths-based assessment
- Activities to increase provider capacity

Period of Performance

September 2019 - September 2021

Grant Email

SUPPORTgrant@dmas.virginia.gov

Information

- Virginia Medicaid Agency Awarded Federal Grant to Combat Opioid Crisis [pdf]
- Summary of Virginia's SUPPORT Act Goals and Activities [pdf]
- Accessibility Notice [pdf]

Resources

- UCSF National Clinician Consultation Center Warmline [pdf]
- COVID-19 Resource Library [pdf]

Monthly Stakeholder Meetings

- October 2020 [pdf]
- September 2020 [pdf]
- August 2020 [pdf]
- July 2020 [pdf]
- June 2020 [pdf]
- May 2020 [pdf]
- April 2020 [pdf]
- March 2020 [pdf]

Fall 2020 Webinars

- Video: How to Set Up a Preferred OBOT Webinar
- Slide Deck: How to Set Up a Preferred OBOT Webinar [pdf]
- Video: Hepatitis C Treatment Webinar
- Slide Deck: Hepatitis C Treatment Webinar [pdf]
- Fall 2020 Webinar Schedule [pdf]

SUPPORT 101 Webinars

- Session Twenty: "Novel" Substances [pdf]
- Session Nineteen: SUD & LGBTQ+ Clients [pdf]
- Session Eighteen: SUD & Legally-Involved Clients [pdf]
- Session Seventeen: Alcohol & Cannabis [pdf]
- Session Sixteen: SUD and The Family [pdf]
- Session Fifteen: SUD & Cultural Humility [pdf]
- Session Fourteen: Addressing SUD Stigma and Building Provider Empathy [pdf]
- Session Thirteen: Group Therapy Skills [pdf]
- Session Twelve: Individual Therapy Skills [pdf]
- Session Eleven: Co-Occurring Disorders [pdf]
- Session Ten: Screening and Assessment for SUD [pdf]
- Session Nine: SUD Treatment Introduction [pdf]
- Session Eight: Opioids and Stimulants Overview [pdf]
- Session Seven: Substance Use Disorders (SUD) Overview [pdf]
- Session Six: Providing Trauma-Informed Care [pdf]
- Session Five: Withdrawal Syndromes [pdf]
- Session Four: Crisis and Deescalation [pdf]
- Session Three: Suicide Assessment and Screening [pdf]
- Session Two: Client Engagement [pdf]
- Session One: Tele-Behavioral Health in the time of COVID-19 [pdf]
- Dr. Mishka Terplan - Pregnant and Postpartum Care for SUD during COVID-19 [pdf]
- Dr. Mishka Terplan - HIV and HCV Updates [pdf]
- Dr. Mishka Terplan - Chronic Pain and Addiction Treatment [pdf]

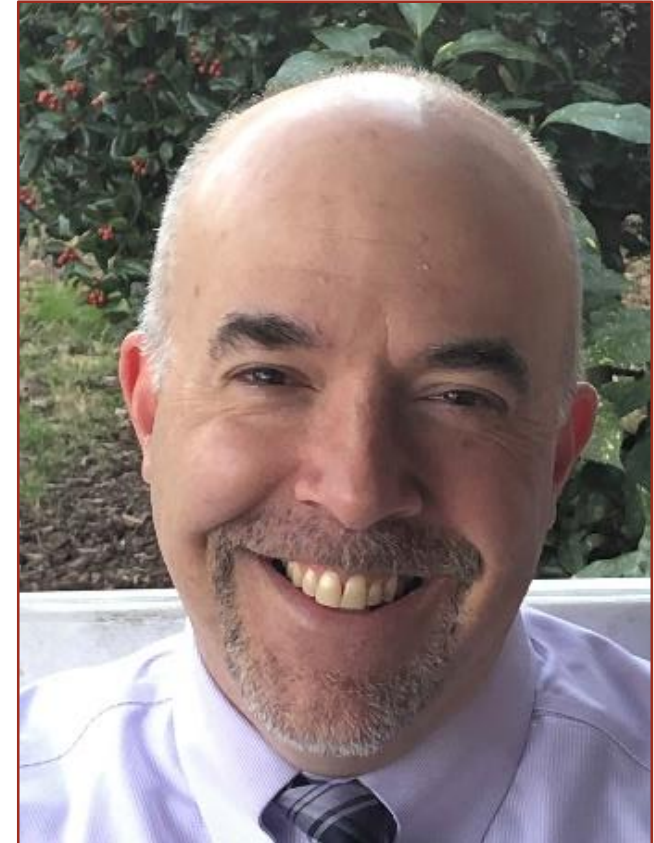
HAMILTON RELAY TRANSCRIBER (CC)

- The grant team has been working closely with Montserrat Serra, DMAS Civil Rights Coordinator, to provide closed captioning for our webinars and stakeholder meetings.
- We were now able to provide closed captioning through Hamilton Relay for all upcoming webinars.
- The link for transcription can be found on the Winter Webinar schedule and will be sent in the chat.

Today's Presenter

Paul Brasler, MA, MSW, LCSW
Behavioral Health Addiction Specialist, DMAS

Paul Brasler is the Behavioral Health Addictions Specialist with the SUPPORT Grant Team at DMAS. Prior to working for DMAS, Paul was the Head of Behavioral Health at Daily Planet Health Services, a Federally-Qualified Health Center in Richmond, Virginia. Paul also works in Emergency Departments conducting Psychiatric and Substance Use Disorder assessments, and in a small medical practice. He has worked in community mental health and in residential treatment settings. He is a national presenter for PESI, specializing in training for clinicians working with high risk clients. His first book, *High Risk Clients: Evidence-based Assessment & Clinical Tools to Recognize and Effectively Respond to Mental Health Crises* was published in 2019.



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ARTS Billing Questions

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THE SUICIDAL CLIENT: *RECOGNIZE SUICIDE RISK*

SUICIDE: THE BIG *WHY?*

There are many reasons people consider, plan, attempt and complete suicide:

- Suicide is a risk associated with some mental illnesses, particularly: Major Depressive Disorder, Bipolar disorders, and Borderline Personality Disorder
 - Substance use disorders, especially alcohol and opioids
- Having a chronic and/or severe medical illness or injury can precipitate suicidal thinking or behaviors
- Suicide is viewed as a logical solution to problems/stress
- Chronic feelings of emptiness, hopelessness or not belonging
- Conflict and sending a message: Suicide as the “Ultimate F_____ you!”

What else?

SUICIDE: THE BIG *WHY?*

- Whatever the reason(s) that a person tries (or succeeds) in killing themselves, most people who make an attempt have thought about killing themselves and have put time into planning their actions
- Suicide is rarely impulsive, even though it might appear that way to others
- Regardless of the reasons that people kill themselves, there is no definitive reason ***why*** people attempt or complete suicide

SUICIDE: EPIDEMIOLOGY

- 10th leading cause of death
- 2nd leading cause of death for people aged 10 – 34
- 48,344 suicides in 2018
 - Suicide rate: 14.2/100,000
 - 132 suicides per day
- 2018 continues a trend that started in 1999, of increasing suicide rates (measured by completed suicides per year per 100,000 people)
 - Prior to 1999, the suicide rate had been decreasing



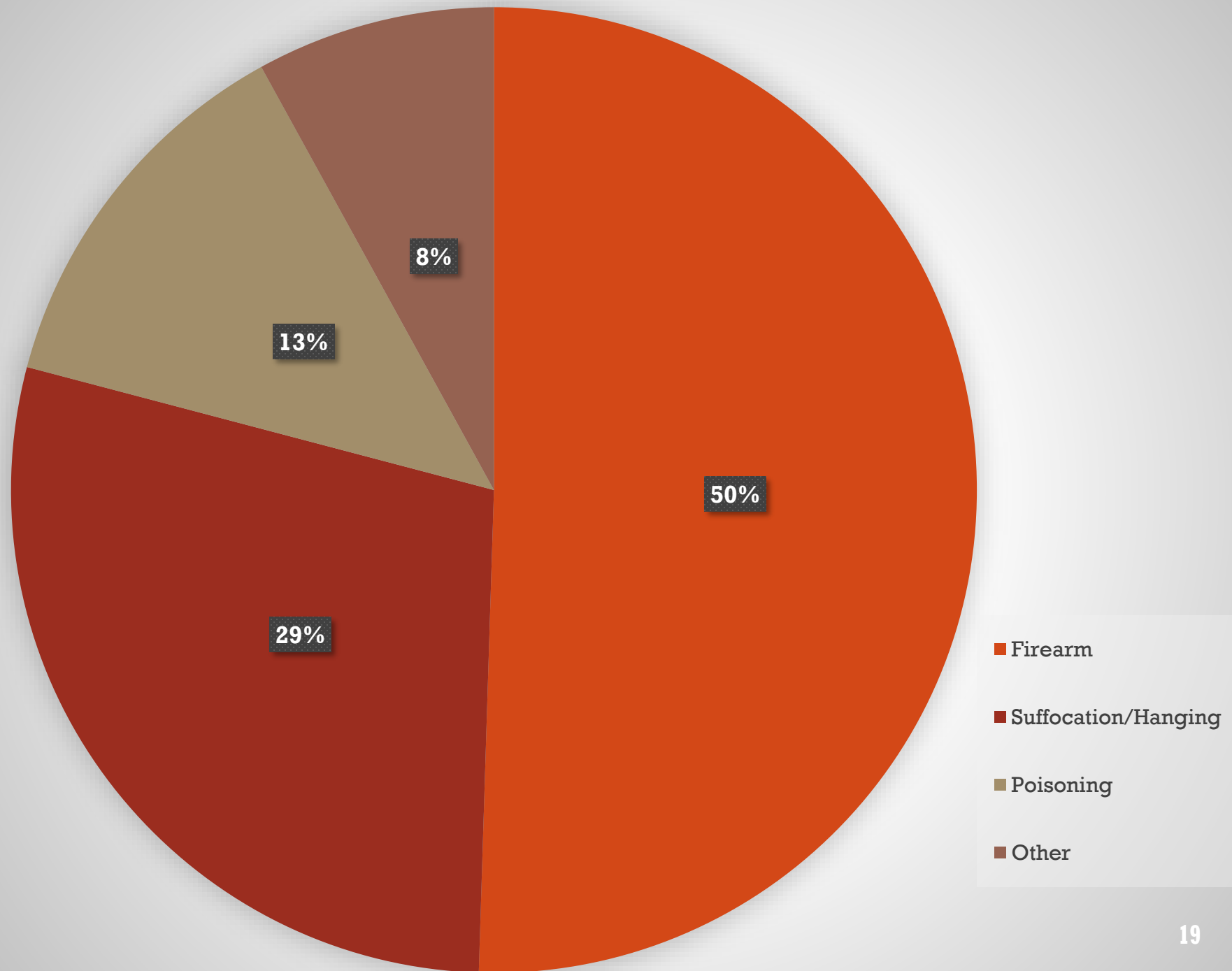
SUICIDE: EPIDEMIOLOGY—2018

- 78% of completed suicides are by males
- 7 completed suicides by males for every 2 completed suicides by females
- 89% of completed suicides are by Caucasians
- 91.6% of completed suicides are by people below the age of 75
- 596 children below the age of 15 killed themselves
- An average of 1 person kills themselves every 10.9 minutes
- Suicides tend to occur early in the week (Mondays & Tuesdays)

SUICIDE: EPIDEMIOLOGY

- Suicide attempts outnumber completed suicide by a factor of 25:1
- Among suicide “completers,” 70% make only one suicide attempt
- 10% of people admitted to a psychiatric hospital for a suicide attempt will eventually kill themselves
- 50% of clients who attempt suicide once will make another attempt
 - ***Risk of repeat suicide attempt is greatest in the first three months after a first attempt***

SUICIDE DEATHS BY METHOD: 2018



SUICIDE RISK FACTORS

“Risk factors are states, traits, or conditions that are significantly more common among eventual known suicides than they are in non-suicidal populations, or in suicide completers versus nonfatal suicide attempters or suicide ideators.” (Maris, p. 65)

We cannot predict suicide, but a solid suicide assessment tries to determine what risk factors are in play and how to best address those factors

SUICIDE RISK FACTORS

- **Mental Illness & Substance Use Disorders:**
 - The severity of the mental illness increases suicide risk
 - Bipolar disorders, Major Depressive Disorder, Substance Use disorders, Borderline Personality Disorder, and Anorexia Nervosa appear to be strongest illness factors
- Recent psychiatric hospitalization
- Feelings of **hopelessness** or **worthlessness**
- Physical illness
- Believing that one is a burden to others
- Past suicide attempts
 - **This is the strongest single suicide risk factor**

SUICIDE RISK FACTORS

- The risk of suicide increases with **age**, however young adults attempt suicide more often than older adults
 - **Middle-aged Caucasian men aged 55 – 64** have the highest suicide rate in the U.S. at 20.2 per 100,000 people (2020), followed closely by **Caucasian men 45 – 54** at a rate of 20.0 per 100,000 people (2020) and **Caucasian men 85 and older** at 19.1 per 100,000 people (2020)
- **Females** attempt suicide four times more frequently than males, but **men** complete suicide 3.5 times more often
 - These age and sex differences appear to be primarily related to the lethality of the method chosen (e.g., firearms, hanging, jumping, etc.), rather than a difference in completion rates for the same method

SUICIDE RISK FACTORS

- The highest risk occurs among those **never married**, followed in descending order of risk by: Widowed, separated or divorced, married without children, and married with children
- **Limited support system/social isolation**
 - Whatever the family structure, **living alone** increases the risk of suicide
- Unemployed, unskilled, and professional individuals are at higher risk for suicide than those who are employed and skilled; a recent sense of failure may lead to higher risk
- Clinicians are at increased risk of suicide

SUICIDE RISK FACTORS

- Child abuse victim (even if client is now an adult)
- Trauma history
- Military veteran
 - In 2017, the suicide rate was 1.5 times higher for Veterans than for non-veterans
- Bullying victim; people are a part of sexual minority groups who may feel isolated or ostracized
- **Family history of suicide**
- Recent stressors
- History of aggression
- Access to **means** – particularly weapons
- An unwillingness to accept help

“WHAT ABOUT CUTTING?”

- **Not just cutting...but**
 - Burning
 - Scratching
 - Banging
 - Hitting Oneself

Non-suicidal self injurious behaviors typically appear between ages 14 and 24

NON-SUICIDAL SELF INJURY

- Years ago, nearly all self-injury behaviors were seen as suicide attempts
- That view shifted when most people who hurt themselves admitted that they were not trying to kill themselves and did not want to die
- This led to a broad view that “cutters” (or people who engage in self-injurious behaviors) are rarely suicidal
- **Current views suggest a more nuanced response that begins by exploring why the person cuts**

SELF- INJURIOUS BEHAVIORS

- Any self-injurious behavior should not be dismissed entirely as something separate from suicidal behaviors and should be explored during assessment and addressed in any safety plan
- Joiner (2005) notes that:
 - “People appear to work up to the act of lethal self-injury. They do so over a long period of time, by gradually accumulating experiences that reduce their fear of self-harm; and they do so in the moment, by first engaging in mild self-injury as a prelude to lethal self-injury” (p. 3)

SUICIDE: PROTECTIVE FACTORS

- **Parenthood**
 - Children in the house
- **Religiosity**—Spiritual connectedness
- Sense of responsibility to family
- Positive coping skills
- Social supports
- Positive therapeutic relationships
- **Future oriented**

CLIENT ASSESSMENT: *ASK THE RIGHT QUESTIONS*

ASSESSMENT OVERVIEW

All clients should receive a comprehensive behavioral health assessment as part of the treatment process, but we need to amend this when working with clients remotely and focus on the following:

- A. Physiological & Safety Needs
- B. Suicide/Lethality assessment**
- C. Mental status exam
- D. Trauma assessment
- E. Substance use assessment

Given that we are having to use tele-behavioral technology, detailed family history, social history and cognitive exams are typically abbreviated (or omitted) during the initial assessment

SUICIDE/LETHALITY ASSESSMENT IN THE CONTEXT OF A SUBSTANCE USE ASSESSMENT

- Given that substance use is a significant risk-factor for suicidal behaviors, it is imperative that a suicide assessment be a part of a SUD assessment
- An excellent suicide screening tool is the Columbia Suicide Severity Index
- If you use any type of screening tool, do not rely solely on any numeric score to make clinical decisions
- I strongly recommend that all providers receive training specific to suicide assessment and intervention

SUICIDE ASSESSMENT (1)

- **Are you having thoughts of killing or hurting yourself?**
 - Another way to ask: *On a scale of 1 to 10 how would you rate your desire to kill yourself?*
 - (If no, have you had thoughts of killing or hurting yourself or wished you were dead in the past two weeks?)
 - If you have thoughts of hurting yourself, or have tried to hurt yourself, do you want to hurt yourself without killing yourself?
- In what way(s) have you thought about killing or hurting yourself?
- Do you have access to the things you might use to kill yourself?

SUICIDE ASSESSMENT (2)

- What has happened that you are thinking of killing yourself?
- How long have you been feeling this way?
- What has kept you from killing yourself even though you feel like killing yourself?
- **Have you ever tried to kill yourself in the past? What did you do?**
 - What happened as a result of this attempt?

SUICIDE ASSESSMENT (3)

- Have you ever been admitted to a psychiatric hospital?
 - (If yes, for what reason?)
 - Did you admit yourself or were you admitted involuntarily?
 - (If no, have you ever been assessed for suicide in an emergency room?)
- Do you see a psychiatrist or counselor in the community?
Have you seen either in the past?
 - Have you found your work with mental health professionals to be helpful? What has worked? What hasn't worked?
- **Has anyone in your family ever died by suicide?**

SUICIDE ASSESSMENT (4)

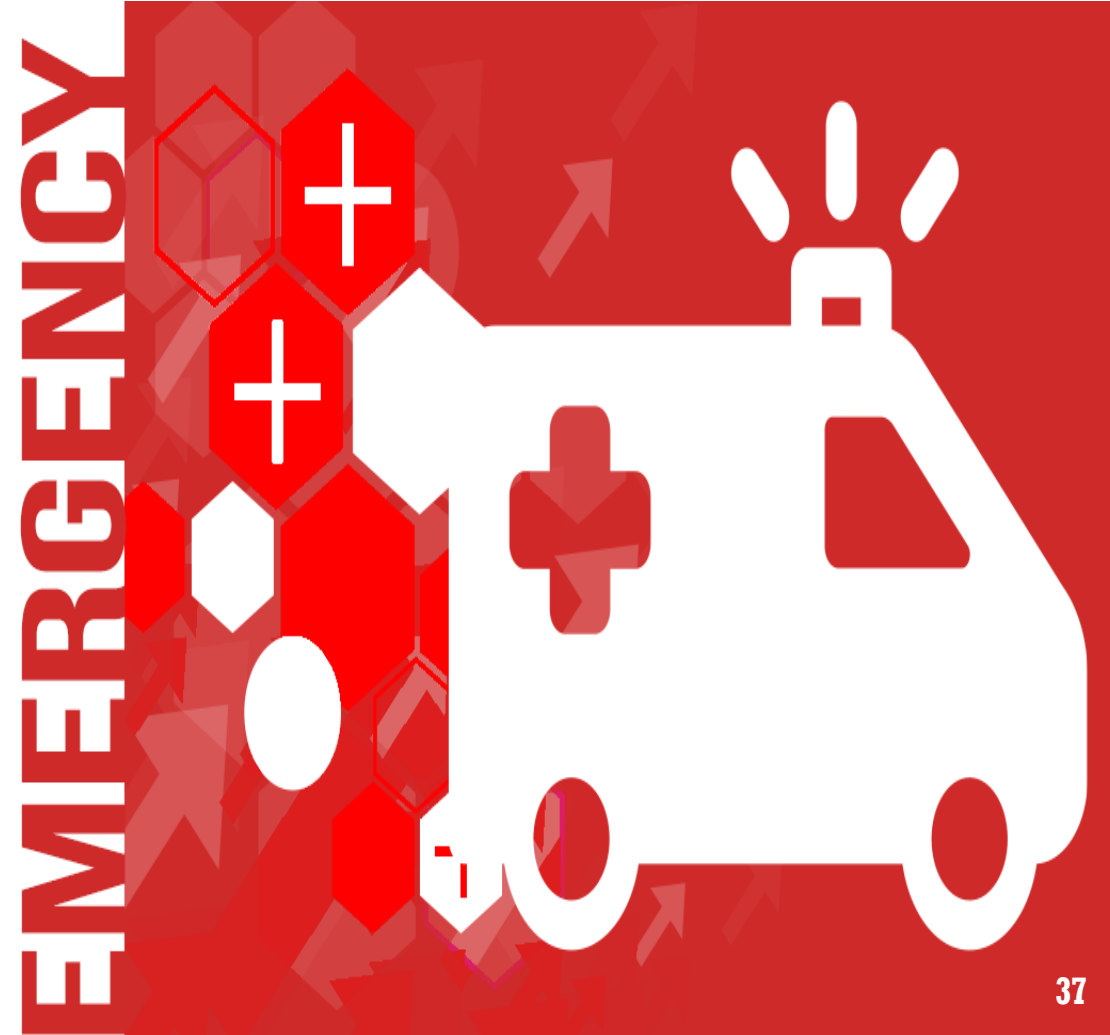
- What do you think happens to us when we die?
- How do you think the people who care about you will feel, or how will they react, if you kill yourself?
- Do you have access to a gun, knives or medications?
 - (Note: I recommend asking this question even if the person has thoughts of killing themselves by other methods [e.g., jumping or hanging] to try to get a better picture of their environment and access to other means)
- Who else knows you feel this way? (And are they present with you or nearby? Can I speak with them?)

LETHALITY ASSESSMENT

- **Are you having thoughts of killing or hurting anyone else?**
 - (If no, have you had any thoughts of killing or hurting someone else in the past two weeks?)
- In what way(s) have you thought about killing or hurting someone else?
- Why do you want to kill this person?
- How long have you been feeling this way?
- What has kept you from hurting this other person even though you feel this way?
- Do you have a history of hurting people?
 - What happened as a result of this?(e.g., Have you ever been charged with assault or malicious wounding?)

CLINICAL RESPONSES TO THE SUICIDE/LETHALITY ASSESSMENT

- **If during the assessment, it is evident that the client clearly intends to harm themselves or others, law enforcement and/or emergency medical services should be summoned immediately**
- An indicator of higher-risk is the level of detail in the planning or attempt of suicide or violence



SUICIDE: ASSESSMENT

- Your immediate safety is important, as is the safety of the patient and others
 - In the community, during an emergency, or if you are not sure, **call the police** or **Emergency Medical Services**
- Pay close attention to **non-verbal cues** (e.g., poor eye contact, flat affect)
- Be aware of **passive-statements** (“this will be over soon,” “no one seems to care about me”)

SUICIDE: WHEN TO HOSPITALIZE

- The more detailed the ideation, plan, and means, the greater the suicide risk
- In situations where there is limited information from the client and/or an inability to construct a reliable safety plan, I typically am very cautious in terms of having the patient remain at home. In these situations, I send them to the hospital
 - ***I always ask myself: Is this a situation that will keep me awake at night if I let them go home and I'm just not sure about their safety...***

SUICIDE: DISPOSITION

- If the client has a suicide plan, or expresses any intent to harm themselves, I send them to the hospital
- Further, if the client refuses to go to the hospital, I initiate the involuntary commitment process
- I have developed relationships with area psychiatric facilities, their administrators and doctors to try to make this process as smooth as possible
- I try to conduct a “soft handoff” whenever possible, so I call the hospital’s emergency department when I am sending them a patient

“DID THEY LEAVE A NOTE?”

- Only 10 – 20% of people who attempt, or complete suicide leave a note: Contrary to media and the entertainment industry, there is often no definitive *Why?*
- **However, the presence of a note denotes greater suicidal intent**
- Currently, most notes are messages left on social media platforms. Thankfully, these messages can lead others to call for help or intervene on behalf of the person making the post

SUICIDE AND CONFIDENTIALITY

- Clients may admit to suicidal ideation or intent with plan, and then note that this information is protected information and tell the clinician they cannot tell anyone without their permission. This is not the case:
 - **Patient safety always trumps confidentiality**
- Usually when I explain the limits of confidentiality to them, they understand. Even if they do not understand, I will act to protect them
- This is where detailed documentation of exactly what happened and what you did in response to your concerns is important

SUICIDE: DISPOSITION

- If the client does not want to go to the hospital and lacks suicidal intent, there may be other options, but only if steps are taken to create a safety plan
- ***If you have doubts, always take the more conservative course: Better to “over-react” than not react enough***
- Historically, Contracts for Safety were used, but these are not a good idea

CAUTION: “CONTRACTING” FOR SAFETY

- **Contracting for Safety:** As part of assessing or supporting a patient's ability to avoid acting on suicidal thoughts, the concept of "contracting for safety" or agreeing to a "no harm contract" has been used in clinical practice for many years
 - First described in the clinical literature in 1973, these contracts were originally designed for clients with whom the clinician had been working with for a long time
- The terms imply that patients can promise clinicians that they will try not to harm themselves when they are suicidal. The terms are not consistently defined or used, and clinicians generally do not receive formal training in suicide assessments
- **Contracts for safety do not protect against legal liability**

CAUTION: “CONTRACTING” FOR SAFETY

- Furthermore, despite their continued wide use in clinical practice:
 - **There is little evidence that such contracts reduce suicide.** As such, contracts may provide a false sense of security (the clinician feels better, but is the client really safe?)
 - Furthermore, can a person with a serious mood or psychotic disorder truly understand, consent and participate in a contracting process? (In my experience, not reliably)
 - Better tools include a detailed lethality assessment and **open dialogue** between patients and clinicians to establish a therapeutic alliance and the **performance of ongoing comprehensive assessments of suicide risk over time**

SAFETY PLANS

- The **patient must be able to participate** in their own safety plan (i.e., if they have cognitive problems or are psychotic, this will usually preclude them from being safe if they are also suicidal)
- Another person (preferably a friend or family member of the patient or a professional caregiver) **must** be involved in developing a safety plan
- Where will the patient be staying and for how long?
- **Weapons** (of any kind, including knives and cutlery) should be removed from the patient's access
- Medication should be stored in a secure place and doses given to the patient individually

SAFETY PLANS

- How will the next few days be structured? **Come up with a plan of things to do to keep the client active**
- In addition to the person who is helping develop the safety plan; **who else can be involved?**
- What outpatient resources are available for the patient? How long will it take him/her to access these resources?
 - What is the wait time? Resolve all financial issues (i.e., make sure the providers take the patient's insurance) and transportation issues
- **What is the plan if the patient's symptoms worsen?** Provide a specific set of instructions of what the patient and their helper should do, including how to contact emergency services

AFTER THE CRISIS

What happens after hospitalization, or your client is released from the Emergency Department?

- Develop and stick to a safety plan—even if this means you need to refer the client back to the hospital
- Monitor for treatment (including medication) compliance
- Increase frequency of face-to-face and telephone contacts
- Focus on emotional regulation and problem solving by anticipating potential problems and barriers and developing options for navigating them
- Try to broaden the client's support system as much as possible—bring in community resources (AA/NA, NAMI, faith communities)

DOCUMENTATION

- **If you don't write it down, it never happened**
- Record, in detail, all aspects of the crisis situation, including any known precipitating events, interventions, outcomes, staff members involved and all contacts with outside agencies
- Do this as quickly as possible following the incident
- **Stick to the facts**; do not presuppose or assume anything
- See documentation as a necessary means to protect yourself, the people you serve, and your organization



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